# Alabama Medicaid

# Enrollment Update Application

For NPI Purposes Only

**Guidelines**

- The completion of this application is only applicable if a provider is not obtaining an organizational NPI(s) for his/her existing group payee number(s).
- By completing this update form, the information on the existing provider file will be changed to the information indicated on this form.
- The provider number(s) that are currently associated with the indicated group payee number(s) will now be associated with the indicated organizational NPI when EDS begins accepting NPI information on claims.
- If an organizational NPI is not indicated, the provider number will be updated and associated with the indicated Individual NPI when EDS begins accepting NPI information on claims.
- If the FEIN (Federal Employee Identification Number) has changed a new enrollment application should be completed.
- Send the original application to:

**EDS Provider Enrollment** **301 Technacenter Drive** **Montgomery, AL 36117**

**Or**

**EDS Provider Enrollment** **Post Office Box 241685** **Montgomery, AL 36124**

# ALABAMA MEDICAID ENROLLMENT UPDATE APPLICATION

*By signing below, I instruct EDS to change the current information on file to the information on this form.

**Please Check Applicable Boxes**

ENROLLMENT UPDATING AS: ☐ Individual
☐ Group/Payee
☐ Facility/Organization

Current Provider Number: (list Group Payee Numbers to be replaced by Organizational NPI or Individual NPI )

_____ _____

_____ _____

_____ _____

Organizational NPI

_____

Individual NPI

_____

## *SECTION 1 – GENERAL INFORMATION*

Group/Company or Last Name First Initial

**(This will be Group/Payee Name)**

Physical Address –(PROVIDER PHYSICAL STREET ADDRESS – See County Codes in Reference Materials Section

Number Street Room/Suite City State ZIP County Code

Business Phone Toll-free Phone Fax Number

Employer's Tax ID Number Legal Name According To The IRS

**(Tax information submitted in this section must match that which is indicated on the W-9 tax form in this application.)**

Mailing Address:

Number Street Room/Suite City State ZIP

Payee Name

**(This is the name of the provider who receives the payment.)**

Payee Address – (EOPs will be mailed to this address)

Number Street Room/Suite City State ZIP County Code

Payee Phone Toll-free Phone Fax Number

Contact Name Contact's Phone Contact's Fax Number

_____ _____

Authorized Signature Date

# W-9

**(Obtain TIN for payments other than interest, dividends, or Form 1099-B gross proceeds)**

# Taxpayer Identification Number Request

Please complete the following information. We are required by law to obtain information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 31 percent federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under section 6723.

Federal law on backup withholding preempts any state or local law remedies, such as any right to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payor is required to withhold 31 percent of its payment to you. Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Instructions:

Complete Part 1 by completing the row of boxes that corresponds to your tax status. Complete Part 2 if you are exempt from Form 1099 reporting. Complete Part 3 to sign and date the form.

## Part 1 Tax Status: (complete one row of boxes)

Individuals:

| Individual Name: | Individual's Social Security Number (SSN): |
|---|---|
| | __ __ __ - __ __ - __ __ __ __ |

A sole proprietorship may have a 'doing business as' trade name, but the legal name is the name of the business owner.

Sole Proprietor:

| Business Owner's Name: | Business Owner's SSN or Employer ID Number: | Business or Trade Name |
|---|---|---|
| | __ __ __ __ __ __ __ __ __ | |

Partnership:

| Name of Partnership: | Partnership's Employer ID Number: | Partnership's Name on IRS records (see IRS mailing label) |
|---|---|---|
| | __ __ - __ __ __ __ __ __ __ | |

A corporation may use an abbreviated name or its initials, but its legal name is the name on the articles of incorporation.

Corporation, exempt charity, or other entity:

| Name of Corporation or Entity: | Employer Identification Number: |
|---|---|
| | __ __ - __ __ __ __ __ __ __ |

## Part 2 Exemption:

If exempt from Form 1099 reporting, check here: ☐
and circle your qualifying exemption reason below

1. Corporation, except there is no exemption for medical and healthcare payments or payments for legal services.
2. Tax Exempt Charity under 501(a), or IRA
3. The United States or any of its agencies or instrumentalities
4. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.
5. A foreign government or any of its political subdivisions.

## Part 3 Signature:

Person completing this form: _____

Signature: _____

Date: _____

Phone: (_____) _____

## *ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION*

Electronic Funds Transfer (EFT) is the **required** payment method to deposit funds for claims approved for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, *provided* the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, **ensuring funds are directly deposited into a specified account.**

The following items are specific to EFT:

- The release of direct deposits depends on the availability of funds. EFT funds are released as directed by the Alabama Medicaid Agency. The earliest date funds are available is Thursday mornings following the checkwrite (Friday in the event of a Monday State holiday).

- Pre-notification to your bank takes place following the application processing. The pre-notification process takes place over a time frame of twenty-one (21) days. Direct deposits when owed to a provider will be made according to the release guidelines in the bullet above. The Explanation of Payment (EOP) Report furnishes the details of individual payments made to the provider's account during the weekly cycle.

- The availability of EOP reports is unaffected by EFT and they typically are received by the end of the week following the checkwrite.

EDS must provide the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs."
>
> The effective date for EFT under the Alabama Medicaid Program is based on release of funds as directed by the Alabama Medicaid Agency. The earliest effective date is Thursday following the checkwrite (if funds were made available from the Agency for the particular provider).

Complete the attached Electronic Funds Transfer Authorization Agreement. **A voided check or an official letter from the bank must be returned with the agreement to EDS.**

## *ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT*

**Note:** Complete all sections below and **attach a voided check or an official letter from the bank for verification purposes.**
**Enter ONE group/payee NPI per form. EFT information is an enrollment requirement.**

Type of Authorization _____New _____Change

| Provider Name | Group/Payee NPI |
|---|---|
| | |
| **Payee Address** | **Provider Phone No.** |
| | |
| | |
| **Bank Name** | **ABA/Transit No.** |
| | |
| **Bank Phone No.** | **Account No.** |
| | |
| **Bank Address** | **Type Account (check one)** |
| | Checking |
| | Savings |

I (we) hereby authorize Alabama Medicaid Agency to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Alabama Medicaid Agency or its fiscal agent. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

_____ _____
Authorized Signature **(Original signature required)** Date

_____ _____
Title Internet Address (if applicable)

_____ _____
Contact Name Phone

Input By_____ Date _____